

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Roselle Ragasa Adult Residential Care Home (ARCH) Corp.	CHAPTER 100.1
Address: 4523 Likini Street, Honolulu, Hawaii 96818	Inspection Date: June 8, 2021 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. FINDINGS Primary care giver (PCG), substitute care giver (SCG) #1, SCG #2, SCG #3 and SCG #4 - No annual examination by a physician. Last examination in June/July 2019. Submit a copy for each with the plan of correction (POC).	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Called physician for annual examination appointment for all the caregivers. Obtained annual examination and copies/record from the physician for the PCG, SCG #1, SCG #2, SCG #3, SCG #4. Annual examination records placed in the POC/SCG binder.</i></p>	<p style="text-align: right;"><i>6/18/21</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. FINDINGS Primary care giver (PCG), substitute care giver (SCG) #1, SCG #2, SCG #3 and SCG #4 - No annual examination prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. Submit a copy for each with the plan of correction (POC).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT I WILL NOT HAPPEN AGAIN?</p> <p><i>I will make a spread sheet to 9/13/21 keep track of PE TB clearance, HTA, CPR dates, check the spread sheet monthly. Three months prior to expiration inform care givers first of date needed, remind caregivers of next scheduled date within 30 days before expiration date make a copy for the file.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness. (b)</u> The licensee shall maintain a first aid kit for emergency use for each Type I ARCH.</p> <p>FINDINGS First aid kit contained a used tube of Pain Relief Neosporin ointment. Expiration date 1/2021. Removed from the first aid kit during the inspection.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;">6/18/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-12 Emergency care of residents and disaster preparedness. (b) The licensee shall maintain a first aid kit for emergency use for each Type I ARCH. FINDINGS First aid kit contained a used tube of Pain Relief Neosporin ointment. Expiration date 1/2021. Removed from the first aid kit during the inspection.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>PCR will check weekly or more frequently than first aid kit does to make any medications waste. And will educate / remind caregivers not to place anything like medication in the kit.</i></p>	<p style="text-align: right;"><i>8/10/21</i></p> <p style="text-align: right;">STATE OF HAWAII DEH-DHCA STATE LICENSING</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-13 Nutrition. (1) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. FINDINGS Resident #1 - "Regular no concentrated sweets (NCS)" diet ordered 4/10/21, 3/23/21 and 3/6/2; however, the diet was not clarified with the physician. NCS diet is a non-standard diet.	<p align="center"> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> </p> <p> Called and verified what is an acceptable diet order from Mrs. Annette Jackson dietitian, instead of regular no concentrated sweets diet Mrs. Jackson recommended. No concentrated sweets diet order to the physician and let of food be avoided when speaking menu was emailed to me by Mrs. Jackson. And copy will be send to the physician for approval. </p>	<p align="center">6/18/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications. (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. FINDINGS Resident #1 - "Indapamine 1.25 mg tab by mouth daily" ordered 2/25/21. The medication label noted "Dispensed on 2/20/20." "Use by 2/19/21."	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Called physician and obtained a medication refill of the indapamine 1.25 mg tab. New refill obtained. Expired medication was disposed or destroyed properly.</i></p>	<p><i>6/18/21</i></p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications. (m)</u> All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 - The April 2021 medication record was not initialed by the care giver on 4/30/21.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;">6/18/21</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-16 Personal care services. (b) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. <u>FINDINGS</u> Resident #1 - Schedule of activities was incomplete.	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Schedule of activities on residents chart was updated and maintained. Will be reviewed and updated as needed.</i></p>	<p><i>6/18/21</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-16 Personal care services. (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. <u>FINDINGS</u> Resident #1 - Schedule of activities was incomplete.	<p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><u>PART 2</u> <u>FUTURE PLAN</u></p> <p>PCG and SCG's will ensure that the schedule of activities is followed and implemented. PCG will review daily or weekly that the schedule or records is followed and completed.</p>	<p>8/10/21</p> <p>STATE OF HAWAII DOH-CHS STATE LICENSING</p> <p>21 AUG 16 P 3:40</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-17 Records and reports. (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 - No observations of the resident's tolerance to "Glucerna 1 bottle daily" ordered 3/6/21 and "Ensure 1 bottle two times daily" ordered 8/15/20 and discontinued on 3/6/21.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;">6/18/21</p>

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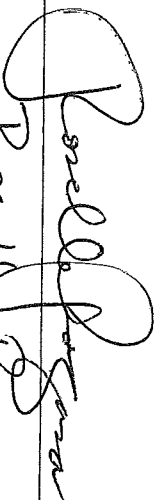
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (h)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p>FINDINGS PCG did not sanitize the lunch dishes and utensils.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p><u>PART 1</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>PCG SCG's will sanitize dishes and utensils every after use and following the correct procedure as required by state rules</p>	<p>6/18/21</p>

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Licensee's/Administrator's Signature:



Print Name:

Roselle Pascara

Date:

6/18/2021

Licensee's/Administrator's Signature:



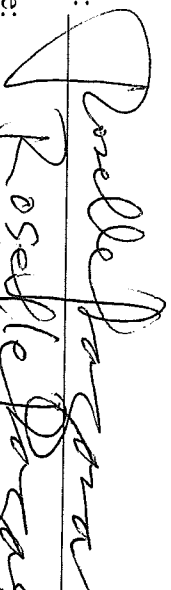
Print Name:

Roselle Pascara

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8/10/2021

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Print Name:

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Date:

9-13-2021